

2864  
Filer 9207 11-23-56 Item 17  
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Boonsboro</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>Boonsboro</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie E. Alexander</u>		4. DATE OF DEATH Month Day Year <u>3 27 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/28/1910</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Huntsberry</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Martz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Charles E. Alexander Boonsboro Md. R.I.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of aortic aneurysm, dissecting type</u> DUE TO (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>21 hrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>56</u> , to <u>3/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>56</u> , and that death occurred at <u>5:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>48 Church St Frederick Md</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		DATE SIGNED <u>3/27/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 29, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Boonsboro Clark Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Boonsboro Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>31 March 56</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	
AGE	
SEX	
RACE	
DATE OF BIRTH	
PLACE OF BIRTH	
CITY	
STATE	
COUNTRY	
DATE OF DEATH	
PLACE OF DEATH	
CITY	
STATE	
COUNTRY	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR	
SIGNATURE OF WITNESS	
SIGNATURE OF DECEASED	
SIGNATURE OF NEXT OF KIN	
SIGNATURE OF BURIAL OFFICIAL	
SIGNATURE OF CHURCH OFFICIAL	
SIGNATURE OF MINISTER	
SIGNATURE OF RABBI	
SIGNATURE OF PRIEST	
SIGNATURE OF BISHOP	
SIGNATURE OF ARCHBISHOP	
SIGNATURE OF PAPAL LEGATE	
SIGNATURE OF VATICAN OFFICIAL	
SIGNATURE OF ROMAN OFFICIAL	
SIGNATURE OF ITALIAN OFFICIAL	
SIGNATURE OF FRENCH OFFICIAL	
SIGNATURE OF BRITISH OFFICIAL	
SIGNATURE OF AMERICAN OFFICIAL	
SIGNATURE OF CANADIAN OFFICIAL	
SIGNATURE OF AUSTRALIAN OFFICIAL	
SIGNATURE OF NEW ZEALAND OFFICIAL	
SIGNATURE OF SOUTH AFRICAN OFFICIAL	
SIGNATURE OF INDIAN OFFICIAL	
SIGNATURE OF CHINESE OFFICIAL	
SIGNATURE OF JAPANESE OFFICIAL	
SIGNATURE OF KOREAN OFFICIAL	
SIGNATURE OF PHILIPPINE OFFICIAL	
SIGNATURE OF THAI OFFICIAL	
SIGNATURE OF BURMESE OFFICIAL	
SIGNATURE OF SINGAPORE OFFICIAL	
SIGNATURE OF HONG KONG OFFICIAL	
SIGNATURE OF TAIWAN OFFICIAL	
SIGNATURE OF HAWAII OFFICIAL	
SIGNATURE OF ALASKA OFFICIAL	
SIGNATURE OF ARIZONA OFFICIAL	
SIGNATURE OF CALIFORNIA OFFICIAL	
SIGNATURE OF COLORADO OFFICIAL	
SIGNATURE OF CONNECTICUT OFFICIAL	
SIGNATURE OF DELAWARE OFFICIAL	
SIGNATURE OF FLORIDA OFFICIAL	
SIGNATURE OF GEORGIA OFFICIAL	
SIGNATURE OF ILLINOIS OFFICIAL	
SIGNATURE OF INDIANA OFFICIAL	
SIGNATURE OF IOWA OFFICIAL	
SIGNATURE OF KANSAS OFFICIAL	
SIGNATURE OF KENTUCKY OFFICIAL	
SIGNATURE OF LOUISIANA OFFICIAL	
SIGNATURE OF MAINE OFFICIAL	
SIGNATURE OF MARYLAND OFFICIAL	
SIGNATURE OF MASSACHUSETTS OFFICIAL	
SIGNATURE OF MICHIGAN OFFICIAL	
SIGNATURE OF MINNESOTA OFFICIAL	
SIGNATURE OF MISSISSIPPI OFFICIAL	
SIGNATURE OF MISSOURI OFFICIAL	
SIGNATURE OF MONTANA OFFICIAL	
SIGNATURE OF NEBRASKA OFFICIAL	
SIGNATURE OF NEVADA OFFICIAL	
SIGNATURE OF NEW HAMPSHIRE OFFICIAL	
SIGNATURE OF NEW JERSEY OFFICIAL	
SIGNATURE OF NEW YORK OFFICIAL	
SIGNATURE OF NORTH CAROLINA OFFICIAL	
SIGNATURE OF NORTH DAKOTA OFFICIAL	
SIGNATURE OF OHIO OFFICIAL	
SIGNATURE OF OKLAHOMA OFFICIAL	
SIGNATURE OF OREGON OFFICIAL	
SIGNATURE OF PENNSYLVANIA OFFICIAL	
SIGNATURE OF RHODE ISLAND OFFICIAL	
SIGNATURE OF SOUTH CAROLINA OFFICIAL	
SIGNATURE OF SOUTH DAKOTA OFFICIAL	
SIGNATURE OF TENNESSEE OFFICIAL	
SIGNATURE OF TEXAS OFFICIAL	
SIGNATURE OF UTAH OFFICIAL	
SIGNATURE OF VERMONT OFFICIAL	
SIGNATURE OF VIRGINIA OFFICIAL	
SIGNATURE OF WASHINGTON OFFICIAL	
SIGNATURE OF WEST VIRGINIA OFFICIAL	
SIGNATURE OF WISCONSIN OFFICIAL	
SIGNATURE OF WYOMING OFFICIAL	

BUREAU V. 8

APR 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2865

## CERTIFICATE OF DEATH

02846

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Thurmont</u>			
c. LENGTH OF STAY IN lb <u>II da</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Minnie First Middle Brice</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 25.1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Thurmont. Fredk Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Frank Portner</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-6122</u>		17. INFORMANT Address <u>Mrs Albert Miesner Thurmont. R.D. I Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>with congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atelectasis of left lung, cause unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/14</u> 19 <u>56</u> , to <u>3/25</u> 19 <u>56</u> , that I last saw the deceased alive on <u>3/24</u> 19 <u>56</u> , and that death occurred at <u>3.4</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E Church St Frederick Md</u> DATE SIGNED <u>3/24/56</u> ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>Raymond E. Creager</u> PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 27. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>United Brethern Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont Fredk. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u> ADDRESS <u>Thurmont. MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Eliz. G. Heck</u>	

# CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE OF DECEASED

BUREAU V. S.

MAR 29 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 14 & 17 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1802847  
Film G194 3/29/56 dmr.

# CERTIFICATE OF DEATH

Reg. Dist. No. 139

2886

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY City	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN Cullen		2 days		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 Victor Cullen State Hospital				625 S. Durham Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Alexander Joseph Budka				March 21, 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	Nov. 27, 1911	44 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Weighed trucks - State Road Comm.				Baltimore, Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Budka				Rose <del>Nowak</del> Nowak			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		None		Deceased, Mrs. Bertha Budka-625 S. Durham			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6 months.	
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis.							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 19, 19 56 to March 21, 19 56 that I last saw the deceased alive on March 21, 19 56, and that death occurred at 3:00 p.m. M, from the causes and on the date stated above.							
SIGNATURE		M. D. Cullen, Md.		DATE SIGNED		March 22, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		3/24/56		Holy Rosary Cemetery		7335 Herman Ave Rd	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3/22/56		J. J. Ryan		George A. Weber		705 S. Cum St	

RECEIVED

MAR 23 1956

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2887

## CERTIFICATE OF DEATH

02848  
Reg. Dist. No. 939

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Guilford - nr. Frederick</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HENRY</b> Last <b>CONLEY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1876</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles William Conley</b>				14. MOTHER'S MAIDEN NAME <b>Martha E. Larrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-16-0018</b>		17. INFORMANT <b>Mrs. Charles H. Conley - Guilford - Frederick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Arterio-Sclerotic heart dis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1950</b> to <b>20 March 1956</b> , that I last saw the deceased alive on <b>19 March 1956</b> , and that death occurred at <b>3:30 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Professional Bldg 3/21/56</b> DATE SIGNED ACTUAL SIGNATURE <b>Charles H. Conley, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>Charles H. Conley, Jr., M.D. Frederick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 22</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Cline &amp; Son - Frederick, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DATE 31 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth S. Hark</b>	

# CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Registration District

County

City

State

Decedent's Name

Age

Sex

Marital Status

Occupation

Place of Birth

Usual Residence

Date of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Place of Death

Physician's Name

Signature of Physician

Signature of Registrar

Official Seal

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Director

Signature of Funeral Home

Signature of Cemetery

Signature of Undertaker

Signature of Mortician

Signature of Embalmer

Signature of Preparer

Signature of Distributor

BUREAU V. S.

MAR 22 1906

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2888

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Emmittsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARBUTUS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5113 ARBUTUS AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Gordon</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 26. 1929</u>
9. AGE (in years last birthday) <u>27</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
13. FATHER'S NAME <u>ARTHUR B. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>FRANCES J. Cooper</u>		Address <u>5113 ARBUTUS AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns entire body</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Body burnt to cinder</u> (a), stating the underlying cause last. (c) <u>Body burnt to cinder</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trailer truck jack knifed &amp; caught fire</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trailer truck jack knifed</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1230</u> a.m. <u>March 6</u> 1956 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 97</u>	
20e. (City or town) <u>N. Emmittsburg</u>		20f. (County) <u>Frederick</u>	
20g. (State) <u>MD.</u>		20h. (City or town) <u>BALTO.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-9-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. HOWARD STRONG</u>		ADDRESS <u>3707 W. North Ave.</u>	
24a. REC'D BY REGISTRAR <u>12 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. H. Huchins</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 12 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

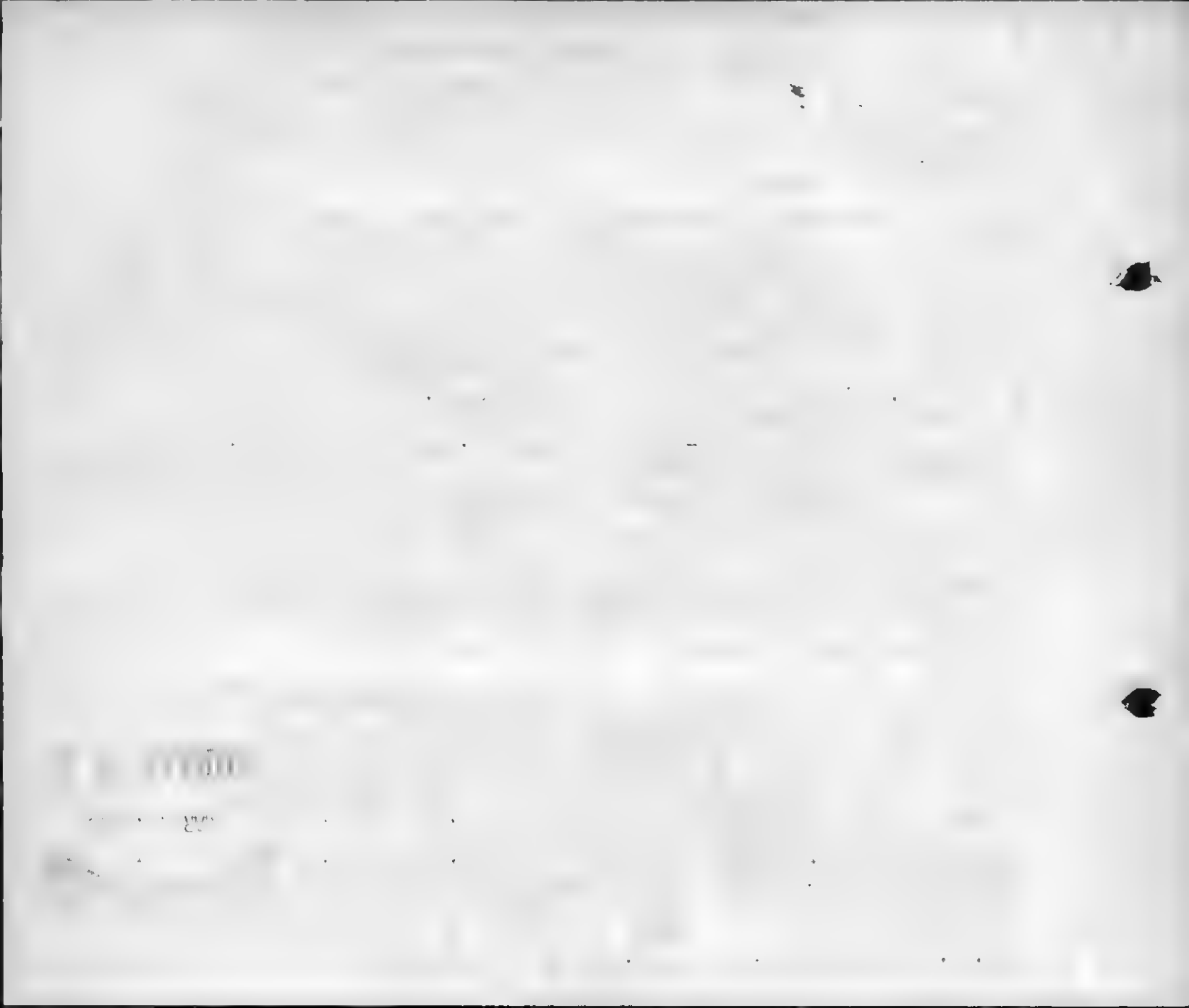
02850

2889

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b>				c. LENGTH OF STAY IN 1b <b>9 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>BESSIE MAY COOPER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 June 1893</b>	
9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR: Months <b>6</b> Days <b>19</b> Hours <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Confectionary</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>David C. Kline</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Abb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-7891</b>		17. INFORMANT <b>Chester O. Cooper, New Market, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1954</b> to <b>3/6</b> , 1956, that I last saw the deceased alive on <b>2/15</b> , 1956, and that death occurred at <b>4:45 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market St., Frederick, Md.</b> DATE SIGNED <b>3/7/56</b> ACTUAL SIGNATURE <b>James B. Thomas</b> M.D. PHYSICIAN'S NAME (Type) <b>James B. Thomas</b> <b>228 N. Market St., Frederick, Md.</b> <b>3/7/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10 March 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 9-56</b>		24b. REGISTRAR'S SIGNATURE <b>Lucian K Falcon</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed. It is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02851

2890

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and campfully filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AIBC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>FREDERICK</u>			
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		(If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>LIBERTYTOWN</u>		<u>1</u> YEARS		OR TOWN <u>LIBERTYTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ORA DELLA CURFMAN</u>				<u>MARCH 7 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>12/9/1896</u>	<u>79</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HOUSEKEEPER</u>		<u>AT HOME</u>		<u>MARYLAND</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>WILLIAM E. VAN FOSSEN</u>				<u>MARY F. STAUFFER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>NO</u>		<u>RIK CURFMAN LIBERTYTOWN MD.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>541X IMMEDIATE CAUSE (A)</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 5, 1956</u> to <u>March 7, 1956</u> that I last saw the deceased alive on <u>March 6, 1956</u>, and that death occurred at <u>3:40 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, State)		<b>DATE SIGNED</b>	
<u>G. A. Mason</u>		<u>J. M. S. S. S.</u>		<u>11111111111111111111</u>		<u>md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/9/56</u>		<u>MT Zion CEMETERY</u>		<u>MEHAIG, MD</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>8 March 1956</u>		<u>Elybeth G. Heck</u>		<u>D. D. HARTLEY &amp; SONS</u>		<u>LIBERTYTOWN MD</u>	

MAR 12 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2856

CERTIFICATE OF DEATH

02852

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland d. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Catoctin Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First Earnest Middle Dalwick Last				4. DATE OF DEATH Month 3 Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 17 1885	
9. AGE (In years last birthday) 70 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman				10b. KIND OF BUSINESS OR INDUSTRY B and O.R.R.Co			
13. FATHER'S NAME George W. Dalwick				14. MOTHER'S MAIDEN NAME Virginia Yontz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-10-1615			
17. INFORMANT Mrs. Madaline Dalwick, Frederick, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Coronary Occlusion (b) DUE TO Coronary Sclerosis (c) DUE TO Age & Senility of Arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 10 hrs 2410
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis & Myocardial Infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Brunswick, Maryland				20g. (County) Brunswick		20h. (State) Maryland	
21. I certify that I attended the deceased from Jan 1956 to Mar 21 1956 that I last saw the deceased alive on Mar 19 1956 and that death occurred at 12:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. T. BRICE M.D. JEFFERSON MD PHYSICIAN'S NAME (Type) A. T. BRICE JEFFERSON MD							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial				22b. DATE THEREOF 3-23-1956		22c. NAME OF CEMETERY OR CREMATORY Park Heights	
22d. LOCATION (City, town, or county) Brunswick, Maryland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Foster				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR 27 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Hicks							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1956

157

## 2867 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>				d. STREET ADDRESS <b>Mt Airy</b>			
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>EBERT</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1870</b>	9. AGE (In years (last) birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Millard Davis</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Mr. Chester M. Davis, Box #272, Carson City, Nev.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>with congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia bilateral</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/17</b> , 19 <b>56</b> , to <b>3/18</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/18</b> , 19 <b>56</b> , and that death occurred at <b>5:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street, Frederick, Md.</b> DATE SIGNED <b>3/20/56</b> ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D. NAME (Type) <b>Dr. Henry V. Chase</b> <b>East Church Street, Frederick, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 21, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>20 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elyse G. Hask</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

DEAD

2868

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. LENGTH OF STAY IN TB <b>15 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK COUNTY HOME</b>		e. STREET ADDRESS <b>DONT KNOW</b>	
3. NAME OF DECEASED (Type or print) First <b>OLIVER</b> Middle <b>W</b> Last <b>DAWSON</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27th 1881</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABOR</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>E.N. DAWSON</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET E. FINN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs Eula FINNEY FROCK</b>		Address <b>R.F.D. 6 Frederick Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4 + 2 + 2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , to <b>July 7, 1956</b> , that I last saw the deceased alive on <b>May 9</b> , 1956, and that death occurred at <b>2-2</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick Md</b> DATE SIGNED <b>7/12/56</b> ACTUAL SIGNATURE <b>H.F. Kline Sr.</b> M.D. <b>H.F. Kline Sr.</b> PHYSICIAN'S NAME (Type) <b>H.F. KLINE Sr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/12/1956</b>	<b>St Olivet</b>	<b>FREDERICK CITY MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G.E. Barton</b>		ADDRESS <b>WALKERSVILLE MD</b>	24a. REC'D BY REGISTRAR <b>DATE 12 March 1956</b>
		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15 2A 000000

## CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) b. COUNTY <b>FREDERICK</b> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYMAR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYMAR</b>	
c. LENGTH OF STAY IN 1b <b>YEARS</b>		d. STREET ADDRESS <b>RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>L</b> Last <b>ETZLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 19 - 1909</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>CLAUDE R ETZLER</b>	
14. MOTHER'S MAIDEN NAME <b>EDNA RIPPEON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>213-24-8129</b>		17. INFORMANT <b>HAZEL METZLER</b> Address <b>MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease aortic insufficiency &amp; stenosis &amp; mitral stenosis</b> DUE TO (c) <b>15 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>November 1953</b> to <b>19 March 1956</b> , that I last saw the deceased alive on <b>19 March 1956</b> , and that death occurred at <b>2 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James S. Stoner, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Walkersville, Md</b> DATE SIGNED <b>20 March 1956</b>	
PHYSICIAN'S NAME (Type) <b>JAMES E. STONER, JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/22/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LOCUST GROVE</b>	22d. LOCATION (City, town, or county) (State) <b>FREDERICK CO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. E. Hartman &amp; Sons</b> ADDRESS <b>Union Bridge Md</b>		24a. REC'D BY REGISTRAR <b>DATE 3/27/56</b>	24b. REGISTRAR'S SIGNATURE <b>L. E. Hartman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2892

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

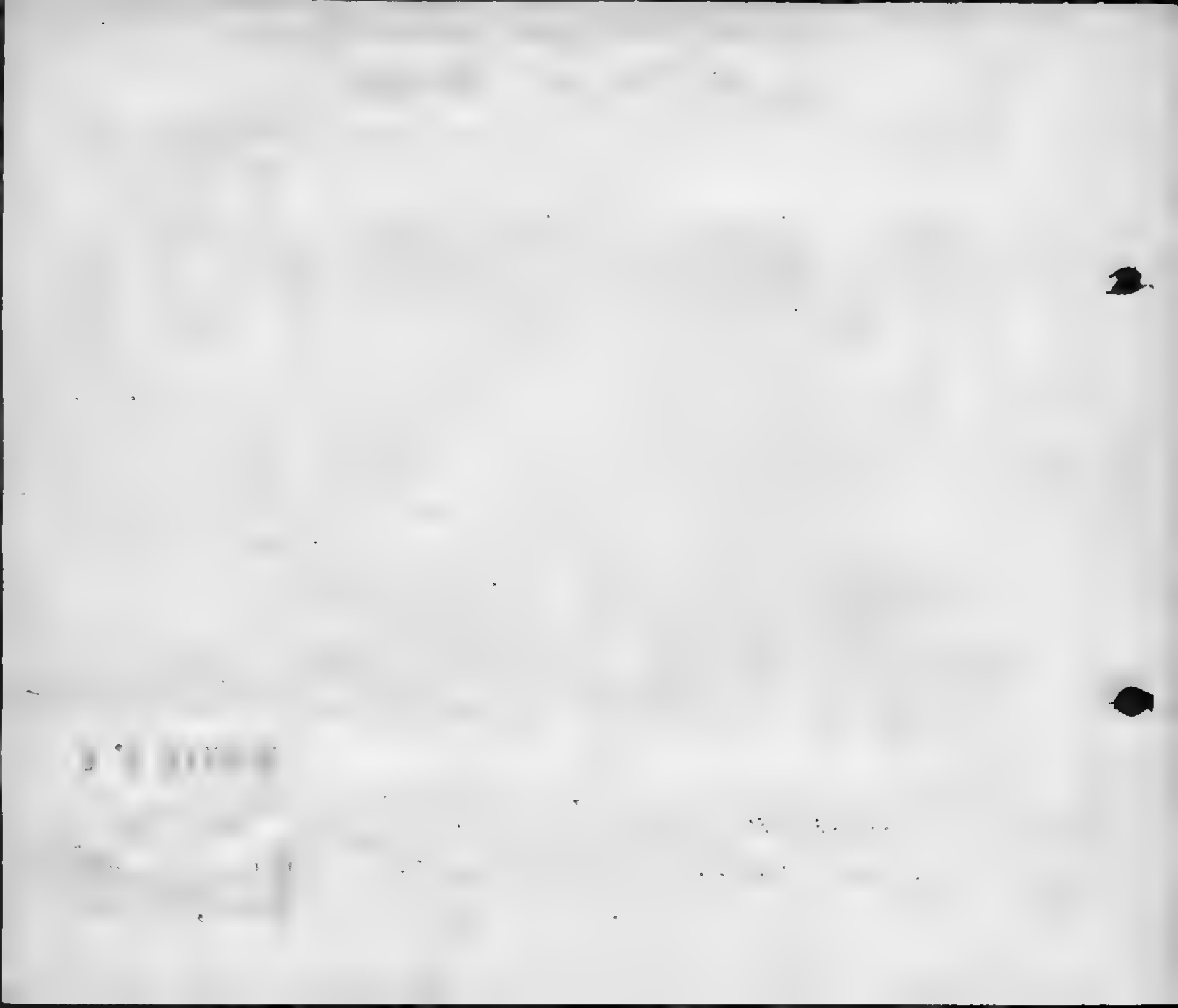
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Emmitsburg, Md.		35 yrs.		TOWN Emmitsburg,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 321 East Main				STREET ADDRESS (If rural give location) 321 East Main			
3. NAME OF DECEASED (Type or Print) Carrie Emma Piror				4. DATE OF DEATH (Month) (Day) (Year) March 26, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 1, 1967	9. AGE last birthday 89 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY On home		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Newcomer				14. MOTHER'S MAIDEN NAME Lillian Hesser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Emmitsburg, 321 East Main Md. Mrs. L. Chao, D. Jellison			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
1. IMMEDIATE CAUSE (A) CARCINOMA Rectum and Kidneys				INTERVAL BETWEEN ONSET AND DEATH Several years			
2. ANTECEDENT CAUSE(S) DUE TO (B) With generalized metastasis							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 12, 1955, to MAR 26, 1956, that I last saw the deceased alive on MARCH 23, 1956, and that death occurred at 1:52AM, from the causes and on the date stated above.							
SIGNATURE Charles R. Williams		M.D. Emmitsburg, Md.		DATE SIGNED March 26, 1956			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF March 28, 56		NAME OF CEMETERY OR CREMATORY Mt. View		LOCATION (City, town, or county) Emmitsburg, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE U. H. Hedrick		25. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison		ADDRESS Emmitsburg, Md.	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 19C 1-55 10M



2859

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>9 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6 East Ninth Street</b>				d. STREET ADDRESS <b>6 East Ninth Street</b>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>MYERS</b> Last <b>GILBERT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1895</b>	9. AGE (in years last birthday) <b>61</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Myers</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Rotz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>202-20-1610</b>		17. INFORMANT <b>Mrs. Paul K. Huber, 6 East Ninth Street, Frederick, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>470.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma right breast.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 29, 1955</b> to <b>March 18, 1956</b> , that I last saw the deceased alive on <b>March 17, 1956</b> , and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street, Frederick, Maryland</b> DATE SIGNED _____							
ACTUAL SIGNATURE <b>Robert S. Turner, Jr.</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Turner</b> <b>East Church Street, Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Northland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Franklin County, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 19 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth V. Hack</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. A. DYKSTRA

GEA

2893  
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Gladhill</u>				4. DATE OF DEATH Month Day Year <u>3 21 1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1880</u>		9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Carlton Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Poffenberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Melvin O. Gladhill, Myersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>17 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1954</u> to <u>Jan 20, 1956</u> , that I last saw the deceased alive on <u>Jan 20, 1956</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elmer Harp</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Middletown 3-23-56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>				<u>Middletown, Md.</u>			
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>3/24/1956</u>		<u>Community Cem., Harmony Frederick Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co.,</u>				ADDRESS <u>Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>26 March 56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

J. V. S.

1881

1881

2870

## CERTIFICATE OF DEATH

Reg. Dist. No.

02859  
139

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>RURAL</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE LEE GRINDER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 31 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3 - 1892</u>	9. AGE (In years last birthday) <u>63</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRILLER - QUARRY CEMENT PLANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS GRINDER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE OTTO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>215-67-0415</u>			
				17. INFORMANT Address <u>LULA H GRINDER UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 1900 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CC</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 15, 1956</u> to <u>Mar 30, 1956</u> that I last saw the deceased alive on <u>Mar 30, 1956</u> and that death occurred at <u>2:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>Mar 31</u> ACTUAL SIGNATURE <u>J. H. Messler</u> M.D. PHYSICIAN'S NAME (Type) <u>J. H. Messler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DD. HARTZLER &amp; SONS UNION BRIDGE MD.</u>				24a. REC'D BY REGISTRAR DATE <u>30 April 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elyse B. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 4 1950

BUREAU V. S.

2871

## CERTIFICATE OF DEATH

02860

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>10 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Uniontown</b>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>Herman</b> Last <b>Haines</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>29</b> Min <b>29</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Nathan Haines</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Stultz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Edward Dingle, Uniontown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial infarction</b> DUE TO <b>Myocardial infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Jan 15 - March 24</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1956</b> to <b>Mar 24, 1956</b> , that I last saw the deceased alive on <b>Mar 24, 1956</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. P. Thomas</b> M.D.				ADDRESS (Street, city or town, state) <b>Frederick, Md.</b>			
PHYSICIAN'S NAME (Type) <b>E. P. Thomas</b>				DATE SIGNED <b>Mar 24, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church of God Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Uniontown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marion C. Fuss</b> ADDRESS <b>Taneytown, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE 31 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hebb</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2894

## CERTIFICATE OF DEATH

Reg. Dist. No.

139

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) b. COUNTY <b>Frederick</b> STATE <b>Md</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sabillasville</b>				c. LENGTH OF STAY IN 1b <b>30 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Omah</b> Middle <b>S.</b> Last <b>Hayman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1900</b>		9. AGE (In years last birthday) <b>56</b> yrs	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Delmar Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Wilmer Hayman</b>				14. MOTHER'S MAIDEN NAME <b>Katie Derrickson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>714-18-0383</b>		17. INFORMANT Address <b>Virgie Hayman Sabillasville, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS, B. LATERAL</b> <b>102X</b> DUE TO <b>FAR ADVANCED, ACTIVE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Oct 1951</b> to <b>3 March 1956</b> that I last saw the deceased alive on <b>2 March 1956</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Blue Ridge Summit Pa 3 March 1956</b>							
ACTUAL PHYSICIAN'S NAME (Type) <b>Harry H. Youngs, Jr., M.D.</b>		SIGNATURE <b>Harry H. Youngs, Jr., M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mch. 6th. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>				ADDRESS <b>Thurmont</b>		24a. REC'D BY REGISTRAR DATE: <b>1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. L. B. Lyons</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 5 1900

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02862

2884

## CERTIFICATE OF DEATH

Reg. Dist. No. 141

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Brunswick</u>		<u>10 yrs.</u>		TOWN <u>Brunswick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>521 West B. Street</u>				STREET ADDRESS (If rural give location) <u>521 West B. Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ARTIE FRANCES HENRY</u>				<u>March 22, 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Nov. 6, 1860</u>	<u>95</u> yrs.	<u>4</u> Months <u>16</u> Days	<u>16</u> Hours <u></u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>		<u>Own Home</u>		<u>Tom's Brook, Virginia</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Scott</u>				<u>Lydia Hahn</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>Mrs. Lillian Cage</u> <u>521 W. B Street, Brunswick, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A)				<u>Myocardial Heart Disease</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
				<u>Years</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>5/11/36</u>, to <u>3/22, 1956</u>, that I last saw the deceased alive on <u>3/22, 1956</u>, and that death occurred at <u>11:30 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>				<b>DATE SIGNED</b> <u>3/24/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Removal</u>				<u>3/23/56</u>			
<b>NAME OF CEMETERY OR CREMATORY</b>				<b>LOCATION (City, town, or county) (State)</b>			
<u>Mt. Hebron Cemetery</u>				<u>Winchester, Virginia</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>				<b>ADDRESS</b>			
<u>[Signature]</u>				<u>Harper's Ferry, West Virginia</u>			
<b>DATE</b> <u>3-24-56</u>							

U. S. A.

1948

1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate shall be filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate shall be filed in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

2872

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>4 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Reich's Ford Road</u>			
3. NAME OF DECEASED (Type or print) First <u>BEATRICE</u> Middle <u>NAOMI</u> Last <u>HOGAN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1898</u>	
9. AGE (In years last birthday) yrs. <u>57</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Elmer E. Hildebrand</u>			
14. MOTHER'S MAIDEN NAME <u>Daisy Miss</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u> <u>None</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. George J. Hogan, Frederick, R.F.D.#6, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumference left tidying</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Meningitis</u> DUE TO (c) <u>Secondary meningitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos. +</u> <u>10 days</u> <u>6 mos. +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>May 10, 1955</u> to <u>March 2, 1956</u> that I last saw the deceased alive on <u>March 2, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>North Market Street, Frederick, Md.</u> DATE SIGNED <u>3/5/56</u>							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. B. O. Thomas Sr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Frederick County, Maryland</u>				22e. (State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR <u>5 March 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	

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## 2873 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (In this place) <u>12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>4 East Potomac</u>			
3. NAME OF DECEASED (Type or Print) <u>Arlington G. Horine</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>3 15 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Aug. 1st. 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Alpheus Horine</u>				14. MOTHER'S MAIDEN NAME <u>Frances Grove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>A.L.W. Horine, Brunswick, Maryland</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
450.1 IMMEDIATE CAUSE (A) <u>Thrombosis, left lower extremity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>10-15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u>						<u>2 WKS.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/3</u> , 19 <u>56</u> , to <u>3/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>56</u> , and that death occurred at <u>4:40</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John W. Chase</u>				ADDRESS (Street, city, town, state) <u>M.D. 4 E Church St Frederick Md 3/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Burkittsville, Maryland</u>	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <u>Mr. Elj. G. Healy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Fute</u>		ADDRESS <u>Brunswick, Maryland</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE 15C 1-55 10M

RECEIVED

2895

# CERTIFICATE OF DEATH

02865

Reg. Dist. No.

148

1. PLACE OF DEATH o. COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Carlton</b>		Middle <b>Vincent</b>		Last <b>Jackson</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1872</b>	
				9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McDonald</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Morris Jackson Thurmont, R.F.D. MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertension</b> DUE TO <b>arteriosclerosis</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs.</b> <b>?</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 9, 1956</b> to <b>Mar. 10, 1956</b> , that I last saw the deceased alive on <b>Mar. 10, 1956</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Franklin M. Birely</b>		M.D. <b>Thurmont Md.</b>		ADDRESS (Street, city or town, state) <b>Thurmont Md.</b>		DATE SIGNED <b>3/12/56</b>	
PHYSICIAN'S NAME (Type) <b>Thurmont MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 13, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Utica Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Utica, Frederick Co. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greiger</b>		ADDRESS <b>Thurmont MD</b>		24a. REC'D BY REGISTRAR <b>DATE, 1-1-56</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Eyles</b>	

QUINTO V.

2874

## CERTIFICATE OF DEATH

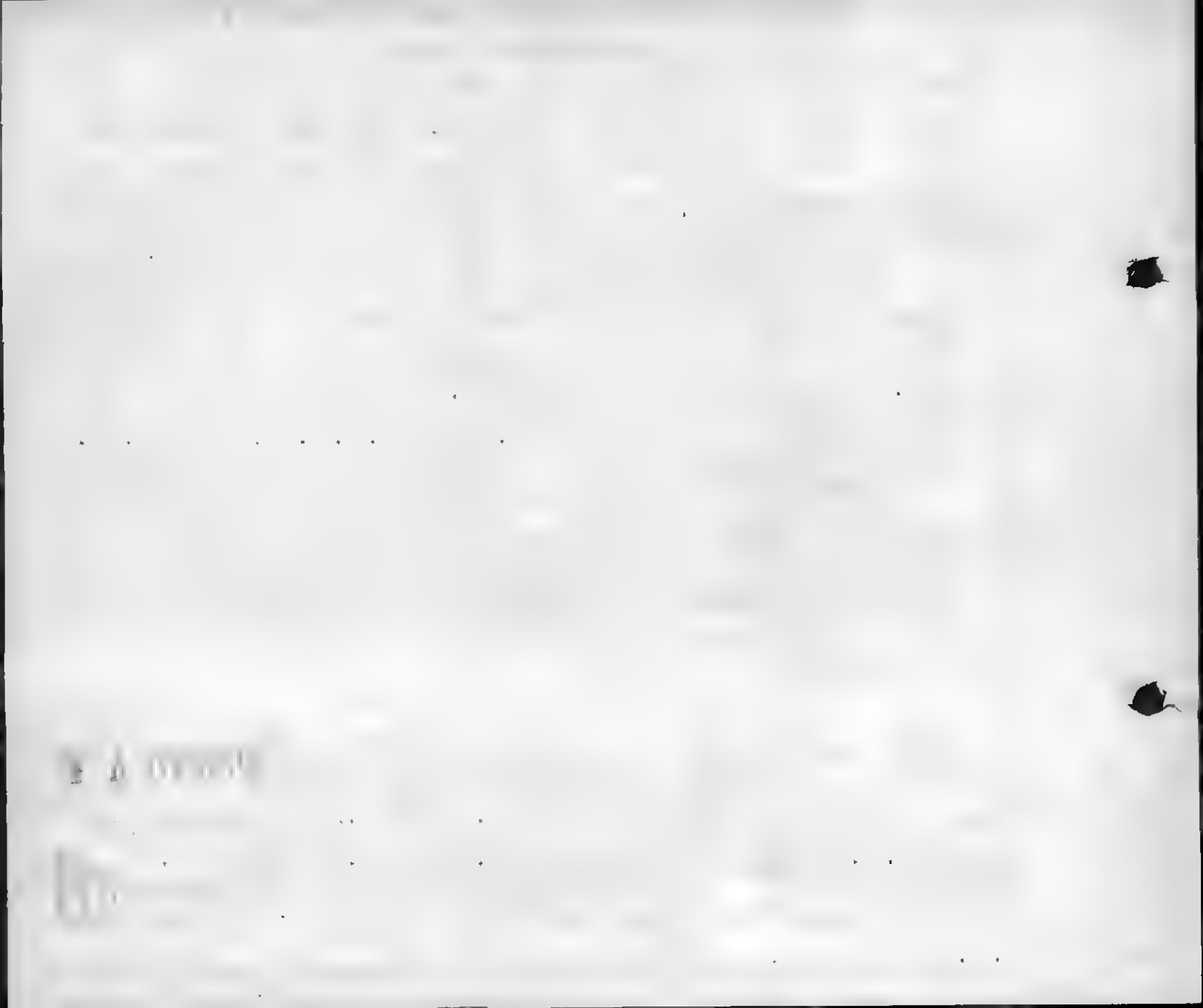
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN b Since-1927			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 217 East Second Street	
3. NAME OF DECEASED (Type or print) First Middle Last ELMEGIA VIRGINIA KRANTZ		4. DATE OF DEATH Month Day Year March 30, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Jan 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. FATHER'S NAME Simeon L. Bast		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Ann J. Cutsail			
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO None	
16. INFORMANT John H. Krantz, R. F. D. #4, Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Appendicitis at cecum Subdiaphragmatic abscess 11 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) Diabetes mellitus			
INTERVAL BETWEEN ONSET AND DEATH 10 min. 34 hr. 11 days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 19, 1956, to Mar 30, 1956, that I last saw the deceased alive on Mar 30, 1956, and that death occurred at 8:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kline		DATE SIGNED 3/31/56	
PHYSICIAN'S NAME (Type) H. F. Kline		7 N. Market St., Frederick, Md. 3/31/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 Apr 1956	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE 31 March 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hark	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2896

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>25 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JO</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>	
3. NAME OF DECEASED (Type or print) <b>Fannie</b> First <b>May</b> Middle <b>Martin</b> Last		4. DATE OF DEATH <b>March</b> Month <b>8</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12. 1875</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Thurmont MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Cyrus Favorite</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Hesson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Esther Weddle Thurmont, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart disease Congestive type</b> <b>4341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 20</b> , 19 <b>54</b> to <b>Mar. 8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Mar. 7</b> , 19 <b>56</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>James K. Gray</b>		M.D. <b>Thurmont Md</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>		<b>Thurmont Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 11. 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk. Co. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Croeger</b>		ADDRESS <b>Thurmont, MD</b>	
24a. REC'D BY REGISTRAR <b>Blanche Eyles</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Eyles</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1956

RECEIVED

## CERTIFICATE OF DEATH

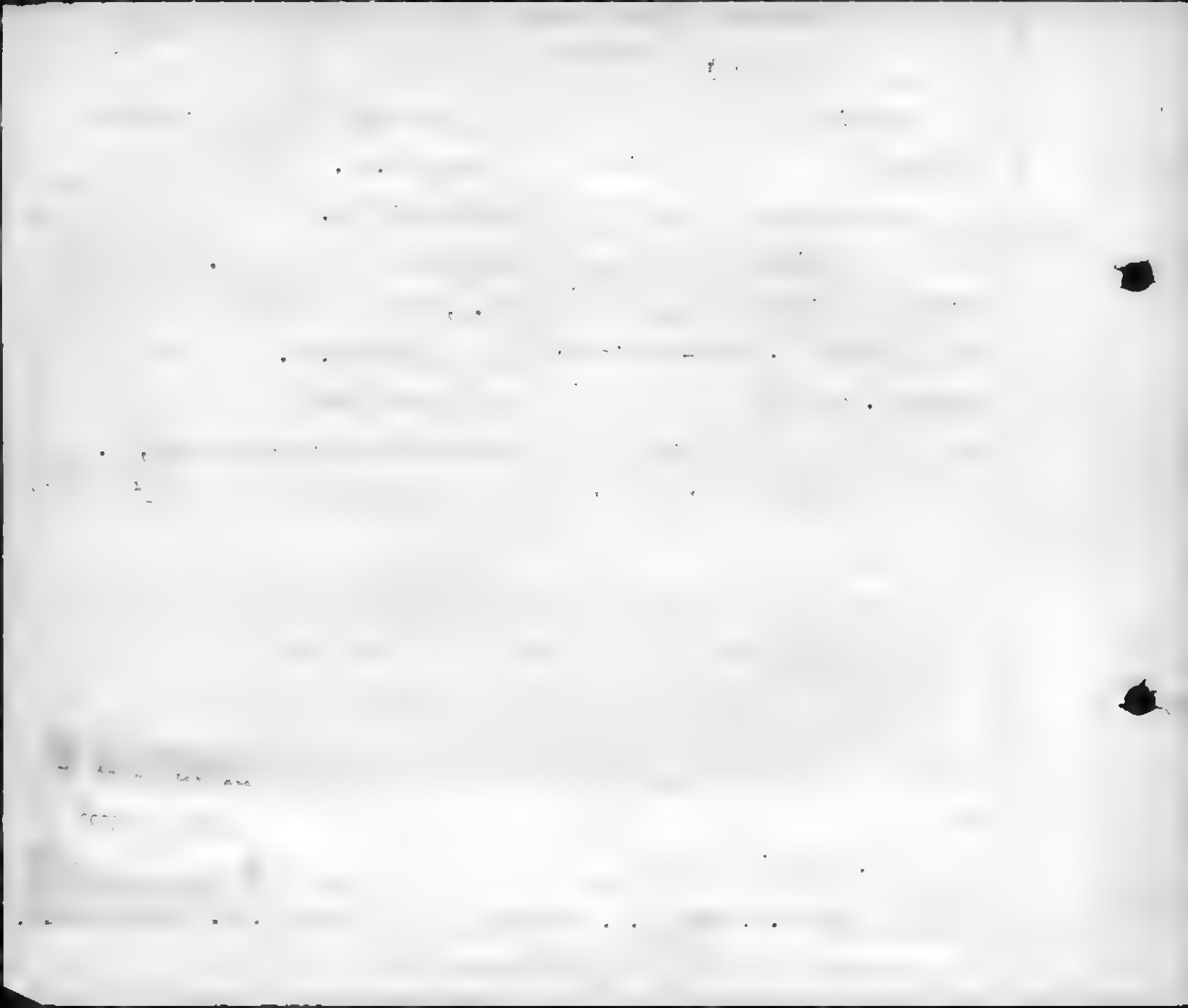
Reg. Dist. No.

2897

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thurmont, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>West Main St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Linnie May McGuigan</b>		4. DATE OF DEATH Month Day Year <b>March 29 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1877</b>
9. AGE (In years last birthday) <b>78</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Month Days Hours Min. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School teacher—Public School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Thurmont, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. McGuigan</b>		14. MOTHER'S MAIDEN NAME <b>Miranda Arthur</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Addie Baltzell-Thurmont, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 4400 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Hypertension</b> DUE TO <b>Arteriosclerotic cardio-vascular disease</b> (c) <b>Carcinoma of ascending colon</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Carcinoma of ascending colon</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days (49)</b> <b>1 mo.</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 26, 1956</b> , to <b>Mar. 29, 1956</b> , that I last saw the deceased alive on <b>Mar. 29, 1956</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. Franklin Birely</b> M.D.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>3/30/56</b>	
PHYSICIAN'S NAME (Type) <b>M. Franklin Birely</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 1, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.B. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Md. Frederick Co.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. O'Quinn</b>		24a. REC'D BY REGISTRAR <b>April 2, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Blanche Gylles</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02870

2875

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Fred</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fred</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - New Windsor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fred mem Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Emma</u> (Middle) <u>L.</u> (Last) <u>Pickett</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>9</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-18-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>60</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Williams</u>		14. MOTHER'S MAIDEN NAME <u>May Shave</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Howard Pickett, New Windsor, MD</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of the head of the pancreas

INTERVAL BETWEEN ONSET AND DEATH

6 mo.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/22/1956, to 3/9/1956, that I last saw the deceased

alive on 3/9/1956, and that death occurred at 2:30 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-12-1956</u>	NAME OF CEMETERY OR CREMATORY <u>Taylorville</u>	LOCATION (City, town, or county) <u>Carroll Co.</u>	(State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>9 March 1956</u>	REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	24. FUNERAL DIRECTOR <u>G.M. Waltz</u>		ADDRESS <u>Winfield Md.</u>	

MAJIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 12 1900

RECEIVED

02871

Reg. Dist. No. 131

2898

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS 18 West College Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY		First Middle SYLVESTER		Last PICKETT		4. DATE OF DEATH Month Day Year March 30, 1956	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 19 Mar 1892	
				9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas W. Pickett				14. MOTHER'S MAIDEN NAME Rosa Florence Brashears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give year or dates of service) 214-10-3395		17. INFORMANT Address Mrs. J. Wilson Stup, 18 West College Terrace, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs 34 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29, 1956, to March 31, 1956, that I last saw the deceased alive on March 29, 1956, and that death occurred at 6:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. North Market Street, Frederick, Md. 3/31/56							
ACTUAL SIGNATURE <u>B. O. Thomas Sr.</u> PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr. North Market Street, Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 Apr 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 31 March 56		24b. REGISTRAR'S SIGNATURE E. J. L. G. Heals	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-2-1

102

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2899

## CERTIFICATE OF DEATH

Reg. Dist. 02872

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived II institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg</b>	
c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Alvin Putman</b>		4. DATE OF DEATH Month Day Year <b>March 28. 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 21. 1879</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. Putman</b>		14. MOTHER'S MAIDEN NAME <b>Phoebe A. Harp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-24-3739</b>	
17. INFORMANT <b>Mrs. Sadie M. Putman</b>		Address <b>Taneytown, R.D. 2, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO <b>Diabetes 9 mel.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Diabetes 9 mel.</b> DUE TO (c) <b>Diabetes 9 mel.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-1-54</b> to <b>3-27-56</b> , that I last saw the deceased alive on <b>3/26</b> , 19 <b>56</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Union Bridge Md</b> DATE SIGNED <b>3-27-56</b> ACTUAL SIGNATURE <b>T. H. Legg</b> M.D. <b>Union Bridge Md</b> PHYSICIAN'S NAME (Type) <b>T. H. Legg</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 31. 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethern. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge. Fredk Co. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		24a. REC'D BY REGISTRAR <b>April 2, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

1960

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2000

## CERTIFICATE OF DEATH

02873

Reg. Dist. No. 13

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>				STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Braddock Heights</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Braddock Heights Fred. Co., Md.</u>				STREET ADDRESS (If rural give location) <u>Braddock Heights Fred. Co., Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Pauline</u> (First) <u>Evitral</u> (Middle) <u>Reid</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>9</u> (Year) <u>56</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March 11, 1971</u>		<b>9. AGE last birthday</b> <u>84</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> *****		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Frederick, Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Edward Holland</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Ann Snowden</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Carter Reid Braddock, Heights Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>170X IMMEDIATE CAUSE (A)</b> <u>Generalized Carcinomatosis</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 mos.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Carcinoma of Right breast</u>						<u>5 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> (County) (State)			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>March 3, 1954</u>, to <u>March 9, 1956</u>, that I last saw the deceased alive on <u>3/7</u>, 19<u>56</u>, and that death occurred at <u>10:45 PM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. C. Reid</u>				<b>DATE SIGNED</b> <u>3/10/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Mar. 12, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Faiview</u>		<b>LOCATION (City, town, or county)</b> <u>Frederick, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Elizabeth S. Herb</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles E. Nicks III</u>			
<b>DATE</b> <u>12 March 1956</u>				<b>ADDRESS</b> <u>Fred. Md.</u>			

Б. А. ОУ

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2876 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02874  
131

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Lifelong</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> d. STREET ADDRESS <u>245 S. Market</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Myrtle</u> First <u>Rosse</u> Middle Last <b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>19</u> Year <u>1956</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>November 1984</u> <b>9. AGE</b> (In years last birthday) <u>61</u> yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Inspector</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hosiery</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Sanlis Rosse</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Bennett</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>214-16-1246</u> <b>17. INFORMANT</b> <u>William S. Bennett</u> Address <u>Frederick, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Strangulation by hanging</u> <u>974X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____				<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> g. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>B. O. Thomas</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>B. O. Thomas</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>March 21, 1956</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Mar. 21, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Olivet Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Frederick, Maryland</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. E. Crane</u> <b>ADDRESS</b> <u>Frederick Md</u>				<b>24a. REC'D BY REG. STRAR</b> <u>DATE 21 March 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Elizabeth Y. Heck</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained by your files. T F FUNERAL DIRECTOR: Page 3 should be used with the registration prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
2877 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 02875									
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b <u>5 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont—RURAL</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shirley M.V. Shaffer</u>					4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1956</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1939</u>		9. AGE (In years last birthday) <u>16</u> yrs.	
								IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Thurmont Fredk Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Paul W. Shaffer</u>					14. MOTHER'S MAIDEN NAME <u>Hazel Duncan</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>No</u> Address <u>Paul W. Shaffer Thurmont MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Abscess</u> DUE TO <u>Basal Meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Basal Meningitis</u> DUE TO <u>Lung Abscess</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. m.</u> Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
SIGNATURE <u>B.O. Thomas</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
NAME (Type) <u>B.O. Thomas</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 17-56</u>				
22a. BURIAL, CREMATION, RESURRECTION <u>Burial</u>			22b. DATE THEREOF <u>Mar. 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont Fredk. Co MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greger</u> ADDRESS <u>Thurmont. MD</u>					24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Ely. G. Zick</u>		

RECEIVED  
MAR 11 1964  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

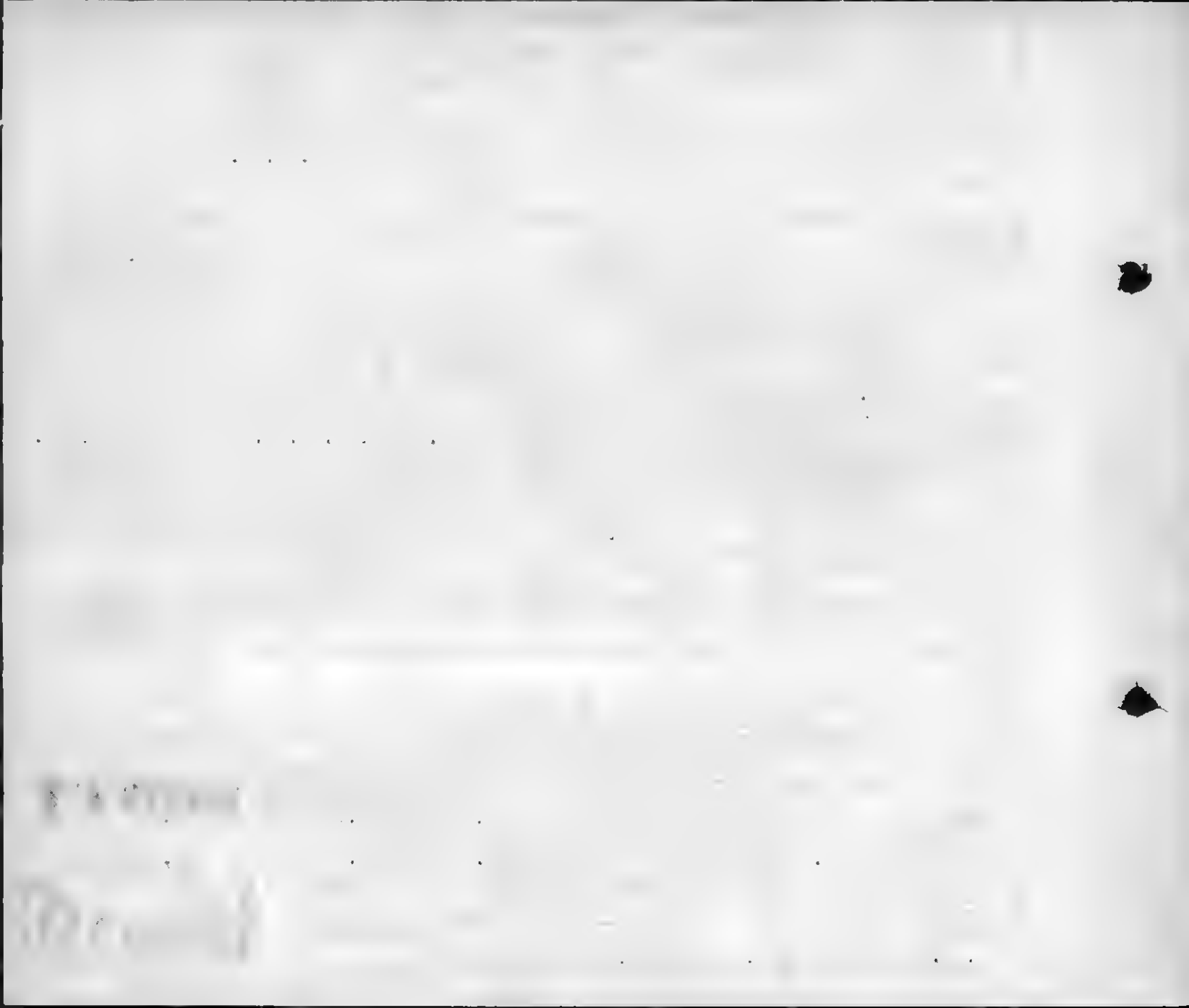
2878

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ALBERT SIER				4. DATE OF DEATH Month Day Year March 27, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Nov 1872	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trackman				10b. KIND OF BUSINESS OR INDUSTRY Railroad Company		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph B. Sier				14. MOTHER'S MAIDEN NAME Sarah Louise Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 705-10-2059		17. INFORMANT Address Miss Cora I. Sier, R. F. D. #6, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs T
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/22, 1956, to 3/27, 1956, that I last saw the deceased alive on 3/26, 1956, and that death occurred at 3:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4 E. Church St., Frederick, Md. 3/27/56 ACTUAL SIGNATURE Henry V. Chase M.D. PHYSICIAN'S NAME (Type) Henry V. Chase 4 E. Church St., Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 29 Mar 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 28 March 56		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, shall file it in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director shall file it in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





WOMAN V. S.

1955

1955-1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2885 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

Reg. Dist. No. 141

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>119 5th. Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> d. STREET ADDRESS <u>119 5th. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lula</u> Middle <u>La Rue</u> Last <u>Talbott</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>4</u> Year <u>1956</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>II-4-1900</u>		<b>9. AGE</b> (In years last birthday) <u>55</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">FUNDERS YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		FUNDERS YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
FUNDERS YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cashier</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>B &amp; O Y.M.C.A.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Henry Talbott</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Holtman</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Marion Talbott, Brunswick, Maryland</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>B.D. Thomas</u> <b>M.D.</b>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>												
<b>EXAMINER'S NAME (Type)</b> <u>B.O. Thomas</u>					<b>DATE SIGNED</b> <u>March 5/1956</u>												
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3-8-1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Heights</u>		<b>22d. LOCATION (City, town, or county) (State)</b> <u>Brunswick, Maryland</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. Lee Feste</u>				<b>ADDRESS</b> <u>Brunswick, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 3-7-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Kathryn H. Brown</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR

2879

## CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR <del>TOWN</del> (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>18 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>356 East Third Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ELSWORTH</b> Last <b>WETZEL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 26, 1904</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>00</b> Hours <b>00</b> Min <b>00</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Corps</b>			
13. FATHER'S NAME <b>Marshall L. Wetzel</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle Ecker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-9095</b>		17. INFORMANT <b>Mrs. Jesse E. Wetzel - 356 E. Third Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung with central metastasis</b> <b>16.5A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>18 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 1955, to <b>March 21</b> , 1956, that I last saw the deceased alive on <b>March 20</b> , 1956, and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Rex R Martin</b>				DATE SIGNED <b>35 E Church 7. 3-23-56</b>			
PHYSICIAN'S NAME (Type) <b>Rex R MARTIN MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 23, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodsboro Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rex R Martin</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>23 March 1956</b>	
						24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Hecker</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the attending physician and complete page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY  
WASHINGTON, D. C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2902

## CERTIFICATE OF DEATH

02880 144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>				c. LENGTH OF STAY IN 1b <b>21 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Thurmont</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Burke Williams</b>				4. DATE OF DEATH Month Day Year <b>March 14 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 11. 1890</b>	9. AGE (In years lost (in day) yrs.) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Petersburg Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Burke</b>				14. MOTHER'S MAIDEN NAME <b>Mariah Harrington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Garland B. Williams Sr. Thurmont. MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Disease Chr. Valvular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Sept. 15 1955</b> to <b>Mar 14 1956</b> , that I last saw the deceased alive on <b>Mar. 5 1956</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Thurmont - Md.</b> DATE SIGNED <b>3/15/56</b>							
ACTUAL SIGNATURE <b>James M. Gray</b>				M.D. <b>Thurmont Md</b>			
PHYSICIAN'S NAME (Type) <b>James M. Gray</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mch. 17. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont Fredk Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>				ADDRESS <b>Thurmont MD</b>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <b>Mr. H. H. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. A. H. H. H. H. H.

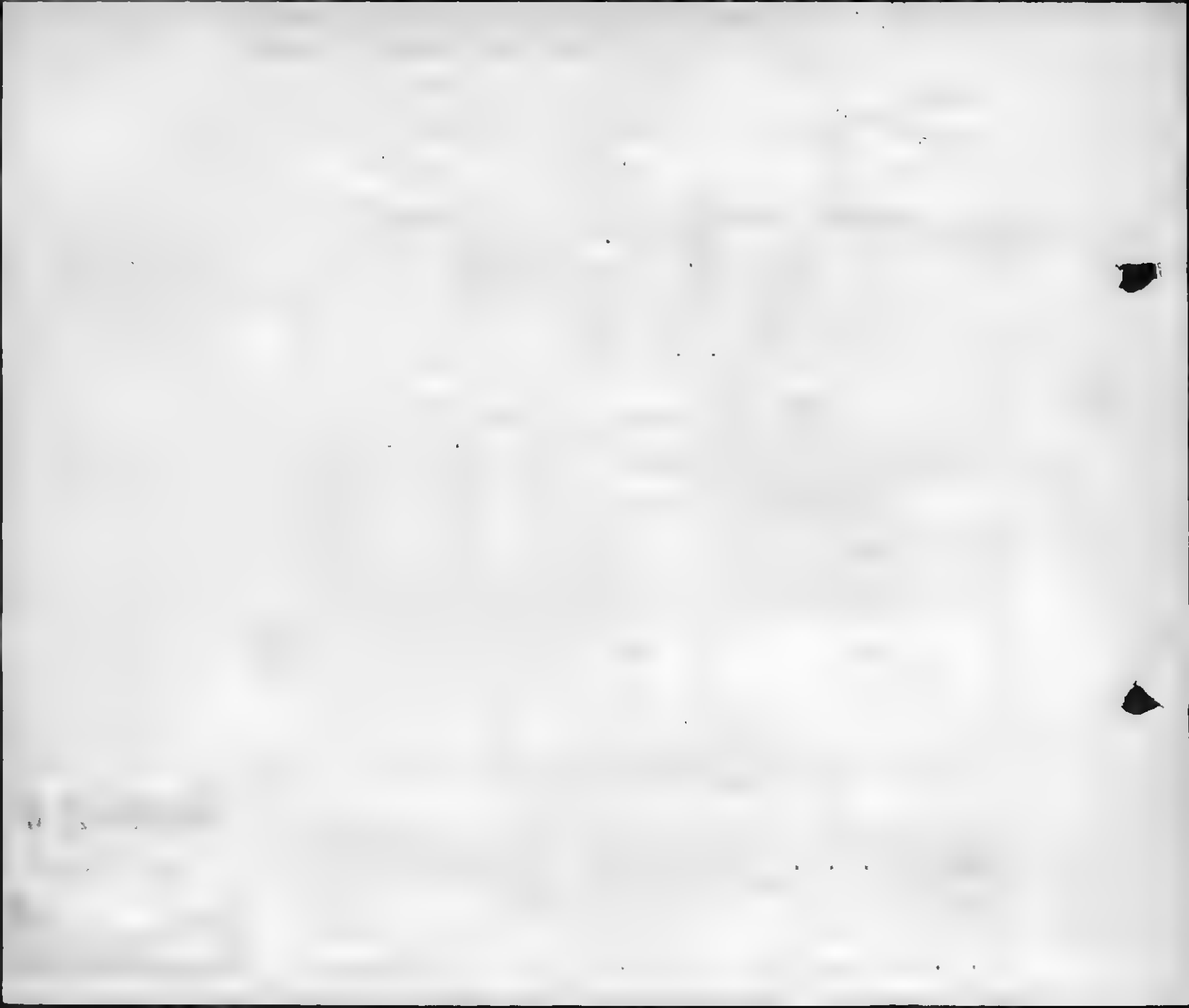
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02881	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										131	
2880										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN TB <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4 East South Street</b>										d. STREET ADDRESS <b>4 East South Street</b>	
3. NAME OF DECEASED (Type or print) <b>(Also known as Margaret M. Wilt)</b> <b>MARGARET M. WILT WILLIAMS</b>					4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1956</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 Sept 1899</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Post Exchange</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army Camp</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Robert Rutherford</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-18-8747</b>		17. INFORMANT <b>George E. Wilt, Adamstown, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>527.2</b> DUE TO <b>Acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b></b> DUE TO <b></b> (c) <b>Autopsy findings - All negative.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <b>Dr. B. O. Thomas</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>March 31, 1956</b>			
EXAMINER'S NAME (Type) <b>Dr. B. O. Thomas</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2 Apr 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Jefferson, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>						24a. REC'D BY REGISTRAR <b>31 Mar 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Herb</b>			



2881

## CERTIFICATE OF DEATH

02882

Reg. Dist. No. 131

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (In this place) <u>1 wk</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodboro</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mrs Elsie MAE Gunkheimer</u>		<b>4. DATE OF DEATH</b> (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>F</u>	<b>COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>May 19, 1876</u>
<b>9. AGE last birthday</b> <u>79</u> yrs.		<b>10. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>run home</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George W. Dudderan</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura E. Butler</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>_____</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Anna Mae Feigh, 208 S. Market St. Fred.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>18. MEDICAL CERTIFICATION</b>
<b>IMMEDIATE CAUSE (A)</b> <u>Congestive Heart Failure</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 mo.</u>
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arteriosclerotic Heart Disease</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Arteriosclerosis and Sinus City</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from March 8, 1956, to March 15, 1956, that I last saw the deceased alive on March 15, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>A. A. Fleane M.D.</u>		<b>DATE SIGNED</b> <u>3/15/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3/18/56</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Elizabell B. Heide</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. C. Barton, Walkersville, Md.</u>	
<b>DATE</b> <u>19 March 1956</u>		<b>ADDRESS</b> <u>Woodboro Md.</u>	

החברה החדשה

1908

2882

## CERTIFICATE OF DEATH

02883

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. <del>CITY</del> OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>I. O. O. F. Home</b>		d. STREET ADDRESS <b>02X-2</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ENGEL</b> Last <b>WOOD</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Feb 1879</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Proprietor - Retail Grocery Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Wood</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ida Engel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-22-5829A</b>	
17. INFORMANT <b>I. O. O. F. Home, Frederick, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b> <b>5 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/1</b> , 19 <b>51</b> , to <b>3/8</b> , 19 <b>56</b> that I last saw the deceased alive on <b>3/7</b> , 19 <b>56</b> , and that death occurred at <b>6:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. M. Smith</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>4 E. Church St., Frederick, Md. 3/9/56</b>	
PHYSICIAN'S NAME (Type) <b>William M. Smith</b>		<b>4 E. Church St., Frederick, Md. 3/9/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12 Mar 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS <b>4 E. Church St., Frederick, Md. 3/9/56</b>	
24a. REC'D BY REGISTRAR <b>9 March 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth B. Hach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship		15. Signature of Informant	
16. Name of Informant		17. Relationship		18. Signature of Informant	
19. Name of Informant		20. Relationship		21. Signature of Informant	
22. Name of Informant		23. Relationship		24. Signature of Informant	
25. Name of Informant		26. Relationship		27. Signature of Informant	
28. Name of Informant		29. Relationship		30. Signature of Informant	
31. Name of Informant		32. Relationship		33. Signature of Informant	
34. Name of Informant		35. Relationship		36. Signature of Informant	
37. Name of Informant		38. Relationship		39. Signature of Informant	
40. Name of Informant		41. Relationship		42. Signature of Informant	
43. Name of Informant		44. Relationship		45. Signature of Informant	
46. Name of Informant		47. Relationship		48. Signature of Informant	
49. Name of Informant		50. Relationship		51. Signature of Informant	
52. Name of Informant		53. Relationship		54. Signature of Informant	
55. Name of Informant		56. Relationship		57. Signature of Informant	
58. Name of Informant		59. Relationship		60. Signature of Informant	
61. Name of Informant		62. Relationship		63. Signature of Informant	
64. Name of Informant		65. Relationship		66. Signature of Informant	
67. Name of Informant		68. Relationship		69. Signature of Informant	
70. Name of Informant		71. Relationship		72. Signature of Informant	
73. Name of Informant		74. Relationship		75. Signature of Informant	
76. Name of Informant		77. Relationship		78. Signature of Informant	
79. Name of Informant		80. Relationship		81. Signature of Informant	
82. Name of Informant		83. Relationship		84. Signature of Informant	
85. Name of Informant		86. Relationship		87. Signature of Informant	
88. Name of Informant		89. Relationship		90. Signature of Informant	
91. Name of Informant		92. Relationship		93. Signature of Informant	
94. Name of Informant		95. Relationship		96. Signature of Informant	
97. Name of Informant		98. Relationship		99. Signature of Informant	
100. Name of Informant		101. Relationship		102. Signature of Informant	

BUREAU V. S.

MAR 12 1956

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural R. F. D. #6</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>			
d. STREET ADDRESS <b>Reich's Ford Road</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>REBECCA</b> Last <b>AMERICA ZIMMERMAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 Dec 1872</b>	
9. AGE (In years last birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Sines</b>				14. MOTHER'S MAIDEN NAME <b>Lauar Stockman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Boyer</b> <b>Mrs. Paul W. Stockman, R. F. D. #6, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>Yes.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1</b> , 19 <b>52</b> to <b>24 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>28 March</b> , 19 <b>56</b> , and that death occurred at <b>4:15 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W. 3rd St., Frederick, Md.</b> DATE SIGNED <b>3-28-56</b> ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D. <b>4 W 3rd St.</b> PHYSICIAN'S NAME (Type) <b>Thomas E. Stone</b> <b>4 W. 3rd St., Frederick, Md.</b> <b>3/28/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>2 Apr 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>31 March 56</b>		24b. REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 8

APR 2 1956

RECEIVED